FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? ☐ Yes ☐ No

If yes, mark the disorder(s) and check who in the family has the disorder.

☐ Insomnia	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Snoring	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleep apnea	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Periodic limb movement	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Sleeptalking	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Narcolepsy	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent
☐ Other: _____	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent

SCHOOL PERFORMANCE (If school-aged)

Your child's year in school (grade): _____

Has your child ever repeated a grade? ☐ No ☐ Yes

Is your child enrolled in any special education class? ☐ No ☐ Yes

How many school days has your child miss so far this year? _____

How many school days did your child miss last year? _____

How many school days was you child late so far this year? _____

How many school days was your child late last year?

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

_____ _____ _____

Signature of Person Completing Form Date Time **(Required)**

_____

Relationship to Patient

Reviewed with Provider:

_____ _____ _____

Provider Signature Date Time **(Required)**